Vitality Integrative Medicine
Health & Nutrition History

Please complete this questionnaire in preparation for your consultation. Your careful consideration of these questions will provide for more effective use of your scheduled consultation time and will help identify priorities.

General Information Date:

First Name: Last Name:			Preferred Name
Date of Birth		Age:	Sex: ☐ M ☐ F
Genetic Background	☐ African American ☐ Native American ☐ Mediterranean	☐ Hispanic ☐ Caucasian ☐ Northern European	☐ Asian ☐ Other *(please note)*
Address: Apt#:		City:	Zip:
Cell Phone			Work Phone
Home Phone			Fax
Email			

Best Way to Reach?

Which method(s) of contact may we use to leave confidential messages?

Job Title/Employer		
Nature of Business		
Primary Physician		Phone:
Address		
Referred by		
Emergency contact name:		
Emergency contact relatioinship:		
Emergency contact phone number:		

Main Health Concerns

What do you hope to achieve in your visit?

Please list your three main health concerns.

1	
2	
3	

When was the last time you felt well?	
Did something trigger your change in health?	

What makes you feel better?	
What makes you feel worse?	
Notes:	

Allergy Information

Please list food, drug, supplement or environmental allergies and symptoms that you experience from each.

FOOD allergies		*Symptoms:*
DRUG allergies		*Symptoms:*
SUPPLEMENT allergies		*Symptoms:*
OTHER: allergies		*Symptoms:*

Medical History

Please check those health conditions that your doctor has diagnosed (provide the date of onset)

GASTROINTESTINAL	**INFLAMMATORY/AUTOIMMUNE**
☐ Irritable Bowel Syndrome	☐ Chronic Fatigue Syndrome
☐ Inflammatory Bowel Disease	☐ Rheumatoid Arthritis
☐ Crohn's Disease	☐ Lupus SLE
☐ Ulcerative Colitis	☐ Poor Immune Function *(frequent infections)*
☐ Gastric or Peptic Ulcer Disease	☐ Severe Infectious Disease
☐ GERD (reflux/heartburn)	☐ Herpes-Genital
☐ Celiac Disease	☐ Multiple Chemical Sensitivities
☐ Hepatitis C or Liver Disease	☐ Gout
☐ Other Digestive:	☐ Other:

CARDIOVASCULAR

- ☐ Heart Disease (heart attack)
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Irregular heart rate – Pacemaker
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse/heart murmur
- ☐ Other Heart & Vascular:

METABOLIC/ENDOCRINE

- ☐ Diabetes ☐ Type 1 or ☐ Type 2
- ☐ Metabolic Syndrome (insulin resistance)
- ☐ Hypoglycemia
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other:

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Migraines
- ☐ Other:

Medications (Please list all prescribed medications you are taking, dose and note reason.)

Name:	*Dose:*	*Reason:*
Name:	*Dose:*	*Reason:*
Name:	*Dose:*	*Reason:*
Name:	*Dose:*	*Reason:*
Name:	*Dose:*	*Reason:*
Name:	*Dose:*	*Reason:*

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, etc.)? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y ☐ N

Surgeries/Hospitalizations

Please list any surgeries or hospitalizations (include dates).

ABO Blood Type (if known)	(circle one) **O A B AB**	Have you ever had a blood transfusion? **Y N**

Please check symptoms you CURRENTLY/RECENTLY *experience*

HEAD

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia

EYES

____ Watery or itchy eyes
____ Swollen, reddened/sticky eyelids
____ Bags, dark circles
____ Blurred or tunnel vision *(does not include near or far-sightedness)*

EARS

____ Earaches, ear infections
____ Drainage from ear
____ Ringing /hearing loss

NOSE

____ Stuffy Nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous

MOUTH/THROAT

____ Chronic coughing
____ Gagging/throat clearing
____ Sore throat, hoarseness
____ Swollen/discolored tongue, gums, lips
____ Canker sores

HEART

____ Irregular /skipped beats
____ Rapid/pounding beats
____ Chest pain

SKIN

____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive sweating

LUNGS

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

DIGESTIVE TRACT

____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain

URINE

___Painful urination
___Urination at night
___Blood in urine
___Frequent urination
__copious __scanty urine
___Retention of urine or difficulty urinating
___Urgent urination
___Incontinence
___Prolapse of bladder or uterus

JOINTS/MUSCLE

____ Pain or aches in joints
____ Arthritis
____ Stiffness/limited movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

WEIGHT

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

ENERGY/ACTIVITY

____ Fatigue/sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness

IMMUNE SYSTEM

___Fever/chills
___Frequent colds/flus
___Lymph node swelling (i.e. "swollen glands")
___Frequent illness
___Bone pain

SEXUAL HISTORY

Sexually active Y / N
_Syphilis _Gonorrhea _Chlamydia
___Genital sores/discharge/itch
___HPV
___Herpes (oral/genital)
___Testicular pain/swelling
___Erection issues
___pain w/intercourse

FEMALE REPRODUCTIVE HISTORY

Date of Last menstrual period:
___Spotting
___Irregularity
___PMS (symptoms:_____)
___menstrual pain
___menopause
___heavy periods
___scanty periods
___early periods ___late periods
pale/bright red/dark red blood ___blood clots
of: pregnancies___ births___ abortions___ living children___
__Leukorrhea (vaginal discharge)

MIND

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

EMOTIONS

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, liver disease, kidney disease, diabetes, autoimmune disease, mental illness or addiction.*

Mother's Health Conditions:

Father's Health Conditions:

Other Family member:	*Health Condition:*
Other Family member:	*Health Condition:*

Dental History

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N If **Y**, how many?

Do you have any ☐ Tooth extractions ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Nutrition History

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N

Please describe:

Please list all **nutritional supplement/herbs** you currently take daily. Please include brand names and dosages (amount per time and times per day). Use a separate page if necessary.

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N If yes, # daily?

Do you have (or had) any eating disorders? ☐ Y ☐ N If yes, please describe.

Exercise & Lifestyle

Please note any physical activities that you engage in regularly along with the intensity, frequency and duration.

ACTIVITY	**TYPE/INTENSITY** *(low-moderate-high)*	**# DAYS/WEEK**	**DURATION** *(minutes)*
Cardio/Aerobic	/		
Strength Training	/		
Yoga/Stretching	/		
Sports or Leisure	/		

Note any problems that limit your physical activity:

Do you smoke? ☐ Y ☐ N	Packs per day?	How many years?	Other exposure? ☐ Y ☐ N
Is there excess stress in your life? ☐ Y ☐ N		Do you easily handle stress? ☐ Y ☐ N	

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Work____ ☐ Family____ ☐ Social____ ☐ Finances____ ☐ Health____ ☐ Other:____

Average number of hours you sleep per night **during the week**? _____ **Weekends**? _____	Trouble falling asleep? ☐ Y ☐ N Trouble staying asleep? ☐ Y ☐ N
If you wake up during the night, note how many times and the cause: (if known):	
Do you feel rested upon waking? ☐ Y ☐ N	Other:

Environmental Information	
Do you have known adverse reactions or environmental sensitivities? ☐ Y ☐ N	If yes, please describe symptoms.
Are you exposed regularly to any of the following? *(check all that apply)*	Please note any regular exposure to harmful chemical/substances.
☐ Cigarette smoke ☐ Auto exhaust/fumes ☐ Dry-cleaned clothes ☐ Nail polish/hair dyes ☐ Heavy metals ☐ Chemicals	☐ Perfumes ☐ Paint fumes ☐ Mold ☐ Pesticides ☐ Fertilizers ☐ Pet dander
Do you use any recreational drugs? If so, please note.	

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)
In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise/physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Thank you for completing this questionnaire. Please send back to Vitality Integrative Medicine prior to your appointment.

Vitality Integrative Medicine
CONSENT FOR TREATMENT

I hereby authorize Vitality Integrative Medicine and its doctors, clinicians and assistants to perform the following specific procedures as necessary to facilitate my diagnosis and treatment:

General Diagnostic Procedures including but not limited to venipuncture and phlebotomy, pap smears, speculum exams, imaging studies, and blood and urine laboratory analysis, general physical exams, neurological and musculoskeletal assessments)

Health education and health counseling, therapeutic exercise, breathing and relaxation exercises

Minor office procedures including dressing a wound, ear cleansing

Herbs/Natural Medicines includes the prescribing of various therapeutic substance including plant, mineral and animal materials. Substances may be given in the form of teas, pills, powders, tinctures (may contain alcohol); topical creams, pastes, plasters, washes; suppositories or other forms. Homeopathic remedies, often highly dilute quantities of naturally occurring substance, may also be used.

Dietary Advice and Therapeutic Nutrition includes the use of foods, diet plans or nutritional supplements for treatment.

Therapeutic Administration of Medicines- includes oral, nasal, auricular, ocular, rectal, vaginal, intramuscular, intradermal, joint, transdermal, subcutaneous or intravenous administration of medicines.

Soft Tissue and Osseous Manipulation includes the use of massage, neuro-muscular techniques, muscle energy stretching or visceral manipulation, as well as manipulations of the extremities and spine including traction, stretching, resistance, and joint play examination.

Electromagnetic therapy, Thermal therapy and Hydrotherapy Therapies includes the use of ultrasound, low and high volt electrical muscle stimulation, transcutaneous electrical stimulation, and microcurrent stimulation, other forms of electromagnetic energy, hot and cold hydrotherapies, sauna therapy, colon hydrotherapy

Devices including durable medical equipment, barrier contraception, and therapeutic devices

Chinese medicine procedures including tongue and pulse assessment, treatment with therapeutic insertion of acupuncture needles, cupping, direct and indirect moxa, use of Chinese herbal/animal/mineral medicines

Potential Risks: Pain, discomfort, blistering, discolorations and minor bruising, bleeding, infection, burns (from thermal therapies and moxibustion), broken needle, loss of consciousness or deep tissue injury from needle insertions, topical procedures, heat or frictional therapies, electromagnetic- and hydrotherapies; allergic reactions to prescribed medicines; soft tissue or bone injury from physical manipulations; and aggravation of pre-existing symptoms.

Potential benefits: Restoration of health and the body's maximal functional capacity, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.

Notice to Pregnant Women: All female patients must alert the doctor if they know or suspect that they are pregnant, since some of the therapies used could present a risk to the pregnancy. Labor-stimulating techniques or any labor-inducing substances will not be used unless the treatment is specifically for the induction of labor. A treatment intended to induce labor requires a letter from a primary care provider authorizing or recommending such a treatment.

I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent and to discontinue participation in these procedures at any time. With this knowledge, I voluntarily consent to the above procedures, realizing that no guarantees have been given to me by Vitality Integrative Medicine or its doctors. I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others unless so directed by me or my representative or otherwise permitted or required by law. I understand that I have the right to review my record and obtain a copy of my record upon request and that obtaining a copy of my record may require payment of a fee.

_____	_____
Guardian/Personal Representative's Name (PRINT)	Patient's Name (PRINT)
_____	_____
Guardian/Personal Representative's Signature	Patient's Signature
_____	_____
Relationship/Representative's Authority	Date

Vitality Integrative Medicine
Patient Payment Policy

Vitality Integrative Medicine is not contracted with any insurance company. The patient agrees to be responsible for paying the costs associated with any visits or labwork, whether the lab fees are billed by the clinic or by the lab itself. At the patient's request, a superbill may be provided, which the patient can submit to their insurance company for potential reimbursement. No reimbursement is guaranteed, as this is dependent upon the terms of the patient's individual health insurance plan. All fees are to be paid at the time of the visit.

Reviewing labwork and creating a treatment plan (including the prescribing of medications) based on that labwork constitutes a medical consultation/evaluation, and the doctor therefore bills for his/her time in doing so. Please understand that, if you are receiving IV treatment, although the doctor may listen to your medical details while in the IV room with you, the IV treatments are a separate service from medical consultations/evaluations, and they are therefore billed separately.

Vitality Integrative Medicine has instituted a 24 hour cancellation policy, in order to reduce the losses incurred from last-minute cancellations. When the office isn't notified in advance of a change in scheduling, this prevents the doctor from seeing another patient at that time. As the time of the doctor is valuable, and the room and doctor are reserved for one patient at a time, and quite a bit of time is reserved for each patient, the clinic therefore requires patients to notify Vitality Integrative Medicine 24 hours of business days,or more, in advance of any appointment if they are not going to be able to come to their scheduled appointment time. No-shows and last-minute cancellations will be subject to the 24 hour cancellation policy.

In order to secure your appointment time, please supply your credit card information, which will be securely maintained on file, and utilized only in the event of a no-show or cancellation within 24 hours of business days of the appointment time (last minute cancellations), or non-payment of services, in order to pay for the services that have been booked. These no-shows or last minute cancellations will be charged for the full price of the type of visit and/or service that was booked. For IV treatment, as IV formulas must be prepared before the visit, in the case that the IV treatment had already been agreed upon with the patient, the charge will be for the scheduled IV. If no specific IV had been scheduled, the charge will be for the IV drip of least cost, which is $154 as of September 24th, 2023. Initial consultation is $350. Follow-up consults are $198.

Cardholder's name as written on the card: _____

Type of card (AMEX, Mastercard, Discover, Visa, Debit etc. are all accepted): _____

Card number: _____

Expiration date: _____

3 digit security code (4 digits for AMEX): _____

Zip code on the account: _____

**Please print your name in the blank, and sign below:

I, _____ , consent to the payment policy and having my card on file charged as per the policy described above, in the event that Vitality Integrative Medicine is not notified of a change in appointment status of the patient within 24 hours of business days from the scheduled appointment time, or to pay for unpaid services/products received.

Cardholder's signature: _____ Date: _____

_____ _____
Guardian/Personal Representative's Name (PRINT) Patient's Name, if different from that of cardholder (PRINT)

_____ _____
Guardian/Personal Representative's Signature Patient's Signature, if different from that of cardholder

_____ _____
Relationship/Representative's authority Date

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it *Notice of Privacy practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:_____

Relationship to Patient:_____

Signature:_____

Date:_____

_____

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date: Initials: Reason: